Statement for the Record by
The Honorable Gordon England
Deputy Secretary of Defense and
The Honorable Gordon Mansfield
Deputy Secretary of Veterans Affairs
Before the Senate Committee on Armed Services
13 February 2008

Chairman Levin, Senator McCain, Members of the Senate Committee on Armed Services, we deeply appreciate your steadfast support of our military and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management and transition of wounded, ill, and injured service members. We are pleased to report that while much work remains to be completed, meaningful progress has been made.

We're delighted to have with us Secretary of the Army Geren, Under Secretary of Defense for Personnel and Readiness Chu, Surgeon General of the Army, Lieutenant General Schoomaker, and Assistant Secretary of Veterans Affairs for Policy and Planning Dunne.

The Administration has worked diligently – commissioning independent review groups, task forces and a Presidential Commission to assess the situation and make recommendations. Central to our efforts, a close partnership between our respective Departments was established, punctuated by formation of the Senior Oversight Committee (SOC) to identify immediate corrective actions and to review and implement recommendations of the external reviews. The SOC continues work to streamline, de-conflict, and expedite the two Departments' efforts to improve support of wounded, ill, and injured service members' recovery, rehabilitation, and reintegration.

Specifically, we have endeavored to improve the Disability Evaluation System, established a Center of Excellence for Psychological Health and Traumatic Brain Injury, established the Federal Recovery Coordination Program, improved data sharing between the Departments of Defense and Veterans Affairs, developed medical facility inspection standards, and improved delivery of pay and benefits.

Senior Oversight Committee

The driving principle guiding SOC efforts is the establishment of a world-class *seamless continuum* that is efficient and effective in meeting the needs of our wounded, ill, and injured service members, veterans and their families. The body is composed of senior DoD and VA representatives and co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs. Its members include: the Service Secretaries, the Chairman or Vice Chairman of the Joint Chiefs of Staff, the Service Chiefs or Vice Chiefs, the Under Secretaries of Defense for Personnel and Readiness and Comptroller, the Under Secretaries of Veterans Affairs for Benefits and Health, the Office of the Secretary of Defense General Counsel, the Assistant Secretary of Defense for Health Affairs, the Director of Administration and Management, the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Veterans Affairs for Policy and Planning, the Deputy Under Secretary of Defense for Plans, and the Veterans Affairs Deputy Chief Information Officer. In short, the SOC brings together on a regular basis the most senior decision makers to ensure wholly informed, timely action.

Supporting the SOC decision-making process is an Overarching Integrated Product Team (OIPT), co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the Department of Veterans Affairs Under Secretary for Benefits and composed of senior officials from both DoD and VA. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work and makes recommendations regarding resource decisions.

Major Initiatives and Improvements

The two Departments are in the process of implementing more than 400 recommendations of five major studies, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act, Public Law No. 110-181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in August 2007, the Secretaries of the Military Departments were directed to use all existing authorities to recruit and retain military and civilian personnel who care for our seriously injured warriors. Described below are the major initiatives now underway.

Disability Evaluation System

The fundamental goal is to improve the continuum of care from the point-of-injury to community reintegration. To that end, in November of last year, a Disability Evaluation System (DES) Pilot test was implemented for disability cases originating at the three major military treatment facilities in the National Capitol Region (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow

Medical Center). The pilot is a service member-centric initiative designed to eliminate the often confusing elements of the two current disability processes of our Departments. Key features include both a single medical examination and single source disability rating. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and compensation.

The pilot addresses those recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission), the Veterans Disability Benefits Commission (Scott Commission), and the DoD Task Force on Mental Health. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices.

To ensure a seamless transition of our wounded, ill, or injured from the care, benefits, and services of DoD to the VA system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the service member and family. The VA is poised to provide benefits and compensation to the veterans participating in the pilot as soon as they transition from the military.

The pilot covers all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing, from the point of service member referral to a Military Department Medical Evaluation Board

(MEB) through compensation and provision of benefits to veterans by the VA. Expansion of the pilot is being considered to address:

- Performance measures – The pilot evaluation plan includes extensive quantitative and qualitative performance measures to ensure our service members obtain all benefits and entitlements due under both DoD and VA law. Although no service members have completely transitioned from the pilot to veteran status, we expect a reasonable sample population to have processed through by mid-June. We'll complete our initial analysis at that time and make a determination regarding expanding the pilot.
- Site assessment – The following criteria will be thoroughly analyzed by both Departments: resources, IT architecture development and fielding, case management effectiveness, training requirements, DES workload (for DoD and VA) in expansion areas, and costs;
- Case management – Most importantly, pilot expansion to a broader population will require training and certification of DES and VA administrative and case management personnel. It is anticipated that certification of the case managers and determination of the appropriate case manager staff size will be the overriding factors that limit or allow expansion of the pilot to other areas.
- Phased expansion – Unlike the pilot's Physical Evaluation Board phases, which are consolidated in the NCR, the medical assessment and MEB phases occur across the Departments at numerous Medical Treatment Facilities (MTFs) and VHA sites. Phased expansion of the pilot should allow MTF site preparation and training on a manageable timeline.

The pilot is part of a larger effort including medical research into the signature injuries of the war and updating the VA Schedule of Rating Disabilities (VASRD). Proposed regulations to update the disability schedule for Traumatic Brain Injury and burns were published in the Federal Register on January 3, 2008.

Psychological Health and TBI

Improvements have been made in addressing issues concerning psychological health (PH) and traumatic brain injury (TBI). The focus of these efforts has been to create and ensure a comprehensive, effective, and individually-focused program dedicated to prevention, protection, identification, diagnosis, treatment, recovery, and rehabilitation for our service members, veterans, and families who deal with these important health conditions.

The DoD has a broad range of programs designed to sustain the health and well-being of every service and family member in the total military community. Because no two individuals are exactly alike, multiple avenues of care are open to create a broad safety net that meets the preferences of the individual. This continuum of care encompasses: prevention and community support services; early intervention to protect and restore before chronicity, and before the member does something rash; service-specific deployment-related preventive and clinical care before, during and after deployment; sustained, high-quality, readily available clinical care along with specialized rehabilitative care for severe injuries or chronic illness, and transition of care for veterans to and from the VA system of care; and a strong foundation of epidemiological, clinical and field research.

Our Departments have partnered in the development of standard clinical practice guidelines for Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. These guidelines help practitioners determine the best available and most appropriate care for PH conditions. In an effort to ensure that providers are trained in best practices, we are partnering in providing training in evidence-based treatment for PTSD.

Traumatic Brain Injury (TBI) can result in decreased reaction time, impaired decision making and judgment, and decreased mental processing. Mild TBI or concussion can reduce mission effectiveness and increase risk to the injured service member and others in the unit. Objective cognitive performance information can give the commander critical information for informed risk decisions in mission planning and execution while providing medical providers with an objective assessment of the extent of the injury and a method of tracking recovery. To facilitate the evaluation and management of TBI cases, DoD has a program to collect baseline neurocognitive information on Active and Reserve personnel before their deployment to combat theaters. The Army already has incorporated neurocognitive assessments as a regular part of its Soldier Readiness Processing in select locations. Additionally, select Air Force units are assessed in Kuwait before going into Iraq.

To ensure all service members are screened appropriately for TBI, questions have been added to Post-Deployment Health Assessment and Post-Deployment Health Reassessment. That same information is shared with VA clinicians as part of an effort to facilitate the continuity of care for the veteran or service member.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for psychological health services has been developed based on a risk-adjusted, population-based model. To augment staffing levels, DoD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service officers in Medical Treatment Facilities to increase available mental health providers for DoD.

DoD and the VA also continue to improve the Mental Health Self Assessment Program. Program expansions, documented in an updated report to Congress submitted in February 2007, included:

- Addition of telephone-based screening for those who do not have access to the Internet including a direct referral to Military OneSource for individuals identified at significant risk;
- Availability of locally tailored, installation level referral sources via the online screening;
- Introduction of the evidence-based Suicide Prevention Program for Department of Defense Education Activity schools to ensure education of children and parents of children who are affected by their sponsor's deployment; and
- Addition of a Spanish language version for all screening tools, expanded educational materials, and integration with the newly developed pilot program on web-based self-paced care for PTSD and depression.

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external

advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the Military Services and VA, promoting and informing best practice development, research, education and training. The DCoE is designed to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with psychological health and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

- Mounting an anti-stigma campaign (the Army's MHAT 5 survey shows that stigma and fears of seeking help are being reduced, but there is more to do);
- Establishing effective outreach and educational initiatives;
- Promulgating a tele-health network for clinical care, monitoring, support and follow-up;
- Coordinating an overarching program of research including all DoD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis and treatment;
- Providing training programs aimed at providers, line leaders, families and community leaders; and
- Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

The FY 07 Supplemental Appropriation provided DoD $900 million in additional funds to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system and are being used to leverage change through optimal planning and execution. The funds have been allocated and distributed in three phases to the Services for execution based on an overall strategic plan created by representatives from DoD and the Services with VA input. Of the $600 million O&M Funds, $566 million (94 percent) has been distributed, including $315 million for PH and $251 million for TBI. The remaining balance is reserved for expansion of promising demonstration programs and for additional costs that emerge as the plans are executed.

Care Management

To improve care management, the complexities between our two care management systems are being reduced through the Federal Recovery Coordination Program, which will identify and integrate care and services for the wounded, ill and injured service member, veteran and their families through recovery, rehabilitation and community reintegration.

New comprehensive practices for better care, management, and transition are being implemented. These efforts include responses to requirements of the National Defense Authorization Act 2008 regarding the improvements to care, management, and transition of recovering service members. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public and private collaboration for care, management and transition,

and the associated training, tracking, and accountability for this care. Our efforts include important reforms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously injured.

The joint FRCP trains and deploys Federal Recovery Coordinators (FRCs) to support medical and non-medical care/case managers in the care, management, and transitioning of seriously wounded, ill, and injured service members, veterans and their families. The FRCP will develop and implement web-based tools, including a Federal Individual Recovery Plan (FIRP) and a National Resource Directory for all care providers and the general public to identify and deliver the full range of medical and non-medical services. To date, the Departments have:

- Hired, trained, and placed eight Federal Recovery Coordinators (FRCs) at three of our busiest Medical Treatment Facilities as recommended by the Dole/Shalala Commission. Additional FRCs will be hired as needed beginning in May;
- Developed a prototype of the Federal Individual Recovery Plan (FIRP) as recommended by the Dole/Shalala Commission; and
- Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and service members, veterans, families, and caregivers.

We are also in the process of:

- Developing a prototype of the National Resource Directory in partnership with Federal, state, and local governments and the private/voluntary sector, with public launch this summer;

- Producing a Family Handbook in partnership with relevant DoD/VA offices;
- Identifying workloads and waiver procedures for Medical Case/Care Managers, Non-Medical Care Managers, and Federal Recovery Coordinators; and
- Developing demonstration projects with states such as California for the seamless reintegration of veterans into local communities.

Data Sharing Between Defense and Veterans Affairs

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology. The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DoD and the VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, and allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added. In December 2007, DoD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a recovery plan for use by Federal Recovery Coordinators was approved in November 2007. A single web portal to support the needs of wounded, ill or injured service members, commonly referred to as the eBenefits Web Portal, is planned based on the VA's successful eVet website.

Medical Facilities Inspection Standards

Progress has made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military Medical Treatment Facilities (MTFs) were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are continuing an aggressive inspection of MTFs on an annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class environment for medical care. In the event a deficiency is identified, the commander of the facility will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically re-inspect the facility until the deficiency is corrected.

All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted FY 08 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

Transition Issues/Pay and Benefits

Service members transitioning from military to civilian life can also benefit from a collaborative effort between DoD and the Department of Labor (DoL). The DoL Pre-Separation Guide, which informs service members and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org.

Another resource tool for transitioning service members is the expanded Small Business Administration's Patriot Express Loan program. The Patriot Express Loan offers a lower interest rate and an accelerated processing time. Loans are available for up to $500,000 and can be used by wounded warriors for most business purposes. DoD has also expanded Wounded Warrior Pay Entitlement information on the Defense Finance and Accounting Service (DFAS) website and other organizations have linked to the website; in July 2007, the DFAS posted an easily understood decision matrix on eligibility for Combat-Related Injury Rehabilitation Pay (CIP) which allows wounded warriors to determine their eligibility for CIP on the website. Additionally, through use of streamlined debt management procedures, DFAS remitted, canceled, or waived debts for over 14,126 wounded warrior accounts totaling approximately $13.17 million as of January 29, 2008.

DoD and the VA have shared information concerning Traumatic Injury Service members Group Life Insurance (TSGLI) and implemented plans replicating best practices. The Army is now placing subject-matter experts at MTFs to provide direct support of the TSGLI application process and improve processing time and TSGLI payment rates. The VA Insurance provider's payment time, upon receipt of a certified claim from the branch of Service, averages between two and four days. DoD has been successful using Congressional authority from the NDAA allowing continuation of deployment related pays for those recovering in the hospital after injury or illness in the combat zone. This ensures no reduction in deployment pays while the Service member is recovering.

We are creating a compensation/benefits website and handbook that will help service members and veterans make informed decisions about their futures. The VA has just commissioned two studies to implement the recommendations of the Dole/Shalala Commission. The first study will evaluate the levels and duration of transition benefit payments to assist veterans and their families while they are in a vocational rehabilitation program. The second study will develop recommendations for creating a schedule for rating veterans' disabilities based upon current concepts of medicine and disability, taking into account the loss of quality of life and loss of earnings resulting from service-connected disabilities. Results of the study will to be provided to the VA by August 2008.

Conclusion

The Senior Oversight Committee and its Overarching Integrated Product Team continue to work diligently to resolve the many outstanding issues while aggressively implementing the recommendations of Dole/Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DoD Inspector General's report on DoD/VA Interagency Care Transition, which is due shortly.

One of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs. The core recommendation of the Dole/Shalala Commission centers on the concept of taking the Department of Defense out of the disability rating business so that DoD can focus on the fit or unfit determination,

streamlining the transition from service member to veteran.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by Dole/Shalala. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless service members, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Chairman Levin, Senator McCain and Members of the Committee, thank you again for your generous support of our wounded, ill, and injured service members, veterans and their families. We look forward to your questions.